EQUIPMENT PRESCRIPTION FORM

The information in this form is for use by the organisation which has requested it and will not otherwise be exchanged with any other party, except in accordance with law. Please see section 15 of this form for privacy information.

IMPORTANT

- Please type or use block letters and **ensure that all sections are complete.** All incomplete forms will be returned, so please give reasons if you are unable to complete a section
- Where there is insufficient space, please attach further information to the back of this form.

This form must be completed for all requests for the following equipment

▪ Wheelchairs	▪ Recumbent trikes	▪ Large exercise equipment
▪ Pressure cushions	▪ Beds	▪ Lounge chairs / tilt recliners
▪ Powered conversion kits	▪ Mattresses	▪ Custom toilet / shower / commode chairs
▪ Hoists	▪ Standing frames	▪ Shower trolleys
▪ Scooters	▪ Tilt tables	▪ Mainstream multifunctional technology (i.e. tablets, smartphones, computers. etc.)
▪ Bikes	▪ Treatment couches	▪ Ramps
▪ Any other single item that exceeds $1,500.00.		

This form must also be completed for repairs or modifications to existing equipment in the above list if it exceeds $1,000 .

Where appropriate please contact the TAC Equipment Contractors to conduct trials of equipment.

TAC Equipment Contractors are:

Country Care Group
Phone 1800 843 224
Email contracts@countrycaregroup.com.au
www.countrycaregroup.com.au

Aidacare
Phone 9981 2100
Email tac@aidacare.com.au
www.aidacare.com.au

Independence Australia (Mobility Aids Australia)
Phone 1800 625 530
Email tac@mobilityaids.com.au
www.independenceaustralia.com.au
www.mobilityaids.com.au

1. Your details

Contracted	Non-Contracted
☐ Framework Occupational Therapist **NOTE:** You must only complete Section 12 if you are requesting follow-up services	☐ Community Occupational Therapist **NOTE:** You do not need to complete Section 12 ☐ Other health professional, e.g. physiotherapist **NOTE:** You do not need to complete Section 12

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2. Client details

Client name

Client address

Postcode

Claim number

Telephone number

Date of Birth
/ /

Date of injury
/ /

Date of assessment
/ /

Date report submitted
/ /

Delivery contact person

Delivery contact telephone number

Delivery address and instructions

3. Current level of function

Transport accident injuries and relevant medical history. C*onsider cognitive function/behaviour and prognosis*

Social situation. *Consider where the client lives, who he/she lives with, any other formal or informal supports, and if there are any plans for change in the future*

Specific functional limitations. *Consider height, weight, upper and lower limb function, posture, balance, cognitive, communication, behavioural or emotional issues resulting from the transport accident injury*

Current functional status. *Include a general overview of the client level of function in the following areas: transfers, mobility, pressure management, personal care, domestic tasks, community access and work/recreation/leisure. Include details specifically relevant to the equipment being prescribed*

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4. Clinical justification

Purpose of recommended equipment. *Consider intended ADLs, social and intended use (indoors, outdoors and frequency)*

Expected measurable outcomes. *Please be specific about how the equipment will maximise functional independence and/or* support clinical goals

5. Discussion with treating healthcare professionals

Provide the outcomes of the discussions you have had with the client's other treating healthcare professionals about your recommendations. *Include any differences in opinion or support for your recommendations*

6. Trials

Did you make your recommendation after trialling products from the *TAC Equipment Contractors* ? ☐ Yes ☐ No

If 'no', please provide clinical reasoning to support why the *TAC Equipment Contactors* products did not meet the client needs

Please note that the trialling of products from the *TAC Equipment Contractors* is mandatory. Failure to do so without clinical justification will result in the *Equipment Prescription Form* being returned.

Details of the trial

Equipment. ***Include all equipment trialled, including the equipment you recommend in section 7***	**Length and location of trial.** ***Include equipment provider name***	**Outcomes and client/carer feedback.** ***Include justification for the equipment you recommend in section 7***

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7. Details of recommended equipment

Details of recommended equipment, including model and specifications

Are non-standard options or non-standard customisations required? Yes ☐ No ☐

If 'yes', please specify feature, function and clinical justification for non-standard options and customisations

Have you considered day-to-day transportation of the equipment?	☐ Yes ☐ No ☐ Not applicable
Have you considered the compatibility with existing equipment and the client'senvironment?	☐ Yes ☐ No
Have you considered the safety of the clientand carers with this equipment?	☐ Yes ☐ No
Has there been multidisciplinary team consensus?	☐ Yes ☐ No
Is this equipment available from the Equipment Contractors? *	☐ Yes ☐ No

*If 'no', the Claims Manager will refer the order to the Equipment Brokerage Team

Additional comments. *Please provide more information where the answer to any of the above is 'no'*

Method of equipment provision

☐ **Purchase**

☐ **Hire**

If hire, for how long?

* Please consider purchase of equipment if hire is for an extended period of time and the hire cost will exceed the cost to purchase the item.

Type of supply

☐ Initial provision ☐ Replacement ☐ Modification

If equipment is being replaced or modified, please specify the following

Type and model of current equipment

Date purchased / /

State Government Victoria

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Limitation of current equipment

Reasons for replacement

8. Quotation

Only required for customised items and items that do not appear on the Equipment List

Has the selected Equipment Contractor provided a written quotation? ☐ Yes ☐ No

If 'no', explain why the equipment is not available through the Equipment Contractors

9. Anticipated maintenance

Consider warranty and supplier's recommended service schedule. For example, requires annual mechanical servicing, etc.

10. Are there any training requirements?

☐ **Yes** ☐ **No**

If 'yes', outline anticipated training requirements for the clientand/or carers

11.Will you conduct a review of the equipment after delivery?

☐ Yes ☐ No

If 'no', please explain why a review is not required

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12.Framework Occupational Therapist only

Prescribing occupational therapist follow-up services

The TACis able to approve a maximum of 6 hours to provide follow–up services.

Explain why follow-up services or training are recommended	**Frequency and duration of follow-up services, *e.g. Weekly follow-up for 2 months***	**Comments, *including additional travel time***

Is a referral for further occupational therapy services required?

☐ **Yes** ☐ **No**

Referral is required if follow-up is anticipated to be greater than 6 hours. If 'yes', please outline the areas that need to be addressed

13.Additional comments

14.Prescribing Occupational Therapist or health professional details

I have discussed the information contained in the *Equipment Prescription Form* with the clientor carers and other members of the treating team, including the requested equipment, the aims, predicted outcomes, maintenance and training requirements.

Provider name, address and phone no. *Use practice stamp where possible*

Signature

Days/hours available

Date

/ /

15.Personal and health information

TAC

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment